My Life, My Health:
Living with Chronic Conditions
Welcome to the Post-Workshop Participant Survey

Congratulations on completing the My Life, My Health workshop! We would appreciate if you would take a few minutes to answer some brief questions. While you may leave any question blank, we encourage you to complete the survey. Your responses are extremely helpful.

This survey is the second in a three part series. It is made up of questions similar to the Pre-Workshop Survey and will be used to track the changes in your responses over time. At the bottom of this page please fill in your name and contact information; this is only for the purpose of matching your information with your attendance and reaching you for the 6-Month Follow-Up survey. Once matched, your name will be removed from all survey responses. Your name will not be recorded in any database.

Your form will be kept confidential. Your responses will not affect any services or programs you are getting. If you have any questions about what is being asked, please ask your Group Leader.

Thank you again for taking time to complete this important survey!

Name: _____ _____

Address:_____ _____

City, State, Zip:_____ _____

Telephone: Day ( )_____-_____ **Evening ( )**_____-_____

Email:_____

How do you prefer to be reached? (Mark all that apply):

O **Mail** O **Phone-Day** O **Phone-Evening** O **Email**

Funding provided by the U.S. Administration on Aging and managed by
the Massachusetts Executive Office of Elderly Affairs and the Department of Public Health

For Program Coordinator Use Only

Participant # _____

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My Life, My Health: Living with Chronic Conditions
Post-Workshop Survey

Office Use Only

Received _____

DPH _____

Participant Health Survey

Instructions:
Please use a pen to answer the questions on both sides of this form.
Please print clearly. Please fill in the circle(s) completely, like this: ●

Questions 1-3 have been omitted on this survey

Physical Activity

4. During the past week, other than your regular daily routine, did you participate in any physical activities or exercises, such as brisk walking, bicycling, dancing, etc.?

- O **Yes**
- O **No**

5. How many days in the past week were you physically active for at least 30 minutes such as brisk walking, bicycling, vacuuming, gardening or anything that causes you to breathe faster (it does not have to be all at one time).

_____ days/ past week

Symptoms

For each of the following questions, please fill in the circle above ONE number that describes your symptoms in the past week. Zero indicates no symptom at all.

6. We are interested in learning whether or not you are affected by fatigue. Select the number below that best describes your fatigue in the past week.

No Fatigue	O	O	O	O	O	O	O	O	O	O	O	**Severe Fatigue**
	0	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	

7. We are interested in learning whether or not you are affected by pain. Select the number below that best describes your pain in the past week.

No Pain	O	O	O	O	O	O	O	O	O	O	O	**Severe Pain**
	0	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	

Please turn over

For Program Coordinator Use Only

Participant # __ __ Facility Code _____ Workshop Start Date ____ /____/_____

Workshop Leaders _____ _____

Symptoms -- continued

8. We are interested in learning whether or not you are affected by stress. Select the number below that best describes your <u>stress</u> in the <u>past week</u>.

No Stress	O	O	O	O	O	O	O	O	O	O	O	**Severe Stress**
	0	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	

9. We are interested in learning whether or not you are affected by sleep problems. Select the number below that best describes your <u>sleep</u> in the <u>past week</u>.

No Problem Sleeping	O	O	O	O	O	O	O	O	O	O	O	**Very Big Problem Sleeping**
	0	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	

Confidence Levels

10. How confident are you that you can do the <u>different tasks and activities</u> needed to manage your health condition in order to reduce your need to see a doctor?

Not at All Confident	O	O	O	O	O	O	O	O	O	O	O	**Totally Confident**
	0	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	

11. How confident are you that you can do things <u>other than just taking medication</u> to reduce how much your illness affects your everyday life?

Not at All Confident	O	O	O	O	O	O	O	O	O	O	O	**Totally Confident**
	0	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	

Thank you for your help!